

		FOR OHF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0020495</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>BROTHER JAMES COURT</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/04</u> to <u>6/30/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>2508 ST. JAMES ROAD</u> <u>SPRINGFIELD</u> <u>62707</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>SANGAMON</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>217-544-4876</u> Fax # <u>217-544-4877</u>		(Type or Print Name) <u>BROTHER DAVID SARNECKI</u>	
IDPA ID Number: <u>43/1588535004</u>		(Title) <u>ADMINISTRATOR</u>	
Date of Initial License for Current Owners: <u>10/1/75</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(C)3</u>		(Print Name and Title) <u>DANIEL J. CALL</u> <u>PARTNER</u> (Firm Name & Address) <u>SIKICH GARDNER & CO, LLP</u> <u>1000 CHURCHILL RD, SPFLD, IL 62702</u> (Telephone) <u>217-793-3363</u> Fax # <u>217-793-3016</u>	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>DANIEL J. CALL</u> Telephone Number: <u>217-793-3363</u>			

Facility Name & ID Number BROTHER JAMES COURT# 0020495 Report Period Beginning: 7/1/04 Ending: 6/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>93</u>	Intermediate/DD	<u>93</u>	<u>33,945</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>30,862</u>	<u>827</u>		<u>31,689</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,862	827		31,689	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.35%

D. How many bed-hold days during this year were paid by the Department?

1,768 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/1/75

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

BROTHER JAMES COURT

0020495

Report Period Beginning:

7/1/04

Ending:

6/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	282,605	24,032	1,213	307,850	156	308,006		308,006		1
2	Food Purchase		155,889		155,889		155,889		155,889		2
3	Housekeeping	63,636	19,520	4,693	87,849		87,849		87,849		3
4	Laundry	53,563	3,658		57,221		57,221		57,221		4
5	Heat and Other Utilities			135,421	135,421		135,421		135,421		5
6	Maintenance	56,565	30,268	77,188	164,021	(11,578)	152,443		152,443		6
7	Other (specify):*										7
8	TOTAL General Services	456,369	233,367	218,515	908,251	(11,422)	896,829		896,829		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,395,646	47,368	3,100	1,446,114	295	1,446,409		1,446,409		10
10a	Therapy			10,794	10,794		10,794		10,794		10a
11	Activities			2,576	2,576	1,327	3,903		3,903		11
12	Social Services	156,084		5,100	161,184		161,184		161,184		12
13	CNA Training										13
14	Program Transportation		15,635		15,635		15,635		15,635		14
15	Other (specify):* EDUCATION			597	597		597		597		15
16	TOTAL Health Care and Programs	1,551,730	63,003	24,567	1,639,300	1,622	1,640,922		1,640,922		16
	C. General Administration										
17	Administrative	57,996			57,996		57,996		57,996		17
18	Directors Fees										18
19	Professional Services			89,531	89,531	5,128	94,659	(112)	94,547		19
20	Dues, Fees, Subscriptions & Promotions			11,767	11,767	(5,128)	6,639		6,639		20
21	Clerical & General Office Expenses	164,461	44,835	42,572	251,868	9,800	261,668	(24,068)	237,600		21
22	Employee Benefits & Payroll Taxes			432,457	432,457		432,457		432,457		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,028	1,028		1,028		1,028		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			46,690	46,690		46,690		46,690		26
27	Other (specify):* DONATIONS			14,113	14,113		14,113	(14,113)			27
28	TOTAL General Administration	222,457	44,835	638,158	905,450	9,800	915,250	(38,293)	876,957		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,230,556	341,205	881,240	3,453,001		3,453,001	(38,293)	3,414,708		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			177,110	177,110		177,110	114,869	291,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			447,110	447,110		447,110	(155,131)	291,979			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,360	212,360		212,360		212,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			212,360	212,360		212,360		212,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,230,556	341,205	1,540,710	4,112,471		4,112,471	(193,424)	3,919,047			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **BROTHER JAMES COURT**

0020495

Report Period Beginning:

7/1/04

Ending:

6/30/05

VI. ADJUSTMENT DETAIL**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(112)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(14,113)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,068)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,293)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(155,131)	34,30	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (155,131)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (193,424)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BROTHER JAMES COURT

ID# 0020495

Report Period Beginning: 7/1/04

Ending: 6/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	DONATIONS	\$ 14,113	27	1
2	FUNDRAISING SALARY	24,068	21	2
3	LEGAL FEES GENERAL CORP WORK	112	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	38,293		49

Summary A

6/30/05

[illegible]

Summary B

6/30/05

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NA	NA	NA	NONE	FRANCISCAN BROTHERS OF THE		
				HOLY CROSS	SPRINGFIELD, IL	RELIGIOUS ORDE
				WEBER CARE CORE	SPRINGFIELD, IL	COMMUNITY LIV
				SPRINGFIELD DEVELOPMENTAL		
				CENTER	SPRINGFIELD, IL	DAY TRAINING PE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 FACILITY RENT	\$ 270,000	FRANCISCAN BROTHERS OF THE HOLY CROSS	100.00%	\$	\$ (270,000)
2	V	30 DEPRECIATION		FRANCISCAN BROTHERS OF THE HOLY CROSS	100.00%	\$ 114,869	\$ 114,869
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 270,000			\$ 114,869	\$ * (155,131)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **BROTHER JAMES COURT** # **0020495** Report Period Beginning: **7/1/04** Ending: **6/30/05**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRO. RAPHAEL KRIEKEM	FOOD SERVICE SUPERVISOR		NONE	NONE	60	100.00	SALARY	\$ 50,004	1,1	1
2											2
3	BRO. LUKE MORIN	RESIDENT CARE COORD		NONE	NONE	60	100.00	SALARY	50,004	10,1	3
4											4
5	BRO. GERALD VOYCHECK	SOCIAL SERVICES DIRECTOR		NONE	NONE	60	100.00	SALARY	53,004	12,1	5
6											6
7	BRO. DAVID SARNECKI	ADMINISTRATOR		NONE	NONE	60	100.00	SALARY	57,996	17,1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 211,008		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **BROTHER JAMES COURT**# **0020495**

Report Period Beginning:

7/1/04

Ending:

6/30/05**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BROTHER JAMES COURT COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0020495

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY			\$	NOT AVAILABLE
2					
3	TOTALS			\$	

Facility Name & ID Number **BROTHER JAMES COURT**# **0020495**

Report Period Beginning:

7/1/04

Ending:

6/30/05**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1975	1975	\$ 1,003,250	\$	30	\$ 7,716	\$ 7,716	\$ 1,003,250	4
5			1996	1996	1,251,493		30	41,716	41,716	375,448	5
6			1997	1997	1,256,490		30	41,883	41,883	318,771	6
7											7
8											8
	Improvement Type**										
9		NEW WING-HEATING AND AIR CONDITIONING		1997	18,883		30	629	629	5,088	9
10		REPAVE PARKING LOT		1986	42,236		10			42,236	10
11		PAINTING/DECORATING		1979	2,591		5			2,591	11
12		BJC-BLDG IMPROVEMENTS		1980	16,233		11			16,233	12
13		BJC-BLDG IMPROVEMENTS		1984	21,419		10			21,419	13
14		BJC-REMODELING		1987	69,555		10			69,555	14
15		BJC-WATER LINE		1987	14,120		20	706	706	12,002	15
16		INSULATION		1991	9,175		15	612	612	8,512	16
17		ELECTRICAL REPAIR		1991	613		10			613	17
18		BOILER TANK REMOVAL		1992	15,089		20	754	754	9,968	18
19		TANK REMOVAL		1992	8,500		10			8,500	19
20		DISHWASHING ROOM SERVER		1992	10,680		20	534	534	7,209	20
21		BJC-STEAM LINE		1985	14,479		10			14,479	21
22		BJC-BLDG IMPROVEMENTS		1975	19,600		24			19,600	22
23		BJC-DINING AREA REMODELING		1976	34,951		10			34,951	23
24		BJC-SIDEWALK/PATIO		1976	3,545		10			3,545	24
25		BJC-BIKE RINK		1978	2,500		50			2,500	25
26		BJC-AIR CONDITIONING SYSTEM		1979	22,876		10			22,876	26
27		BJC-SITE IMPROVEMENT		1979	1,440		26	32	32	1,440	27
28		ROOF		1986	12,166		10			12,166	28
29		ROOFING		1988	45,811		10			45,811	29
30		REMODELING		1989	46,656		10			46,656	30
31		WATER LINE		1989	3,166		20	158	158	2,612	31
32		SEWAGE TREATMENT PLANT		1990	6,411		20	321	321	4,862	32
33		TANK REMOVAL		1991	9,809		10			9,809	33
34		PARKING LOT		1992	10,452		10			10,452	34
35		PAINT RESTROOMS		1992	230		5			230	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	BOILER ROOM REMODELING	1993	\$ 15,106	\$	20	\$ 755	\$ 755	\$ 9,070		37
38	REPAVE PARKING LOT	1994	850		10	21	21	850		38
39	PUMP	1994	734		10			734		39
40	AIR CONDITIONER WORK	1994	943		10			943		40
41	BOILER ROOM PROJECT	1994	170,330		20	8,517	8,517	69,072		41
42	LAND IMPROVEMENT - TREES	1996	3,470		20	173	173	1,533		42
43	BJC-BLDG IMPROVEMENTS	1998	15,712		30	524	524	3,841		43
44	WATER LINE REPAIR	1999	3,101		10	310	310	1,783		44
45	LAND IMPROVEMENT - TREES	1999	25,849		20	1,292	1,292	7,539		45
46	GATE	1999	550		5	37	37	550		46
47	REMODELING	1999	5,773		10	577	577	3,223		47
48	FLOOR	2000	1,683		7	240	240	1,242		48
49	TOTAL LIFE CENTER	1998	122,261		30	4,075	4,075	28,867		49
50	PARKING LOT BLACKTOP	2000	49,310		15	3,287	3,287	15,665		50
51	LEASEHOLD IMPROVEMENTS	1985	15,200		10			15,200		51
52	LEASEHOLD IMPROVEMENTS	1986	19,507		10			19,507		52
53	PAINTING	1987	9,922		23			9,922		53
54	STEEL DOOR	1987	6,020		10			6,020		54
55	WINDOW REPLACEMENT	1987	2,013		10			2,013		55
56	GENERATOR SWITCH	1988	3,335		10			3,335		56
57	REMODEL LOBBY	1989	156,996	5,233	30	5,233		81,551		57
58	BUS HUT	1989	4,715	105	15	105		4,715		58
59	WATER HEATER	1989	6,721		10			6,721		59
60	TRANSFER SWITCH	1989	1,127		10			1,127		60
61	HAET-ENERGY PANEL	1989	8,633		10			8,633		61
62	LEASEHOLD IMPROVEMENTS	1989	6,629	39	10	39		6,629		62
63	ROOF REPAIR	1990	6,928		10			6,928		63
64	REMODELING	1990	6,953	232	30	232		3,515		64
65	OVERHEAD DOOR	1990	1,220		10			1,220		65
66	KITCHEN TANKS	1990	3,089		10			3,089		66
67	PLASTERING	1990	2,586		10			2,586		67
68	REMODEL CEILING	1990	2,970		10			2,970		68
69	LEASEHOLD IMPROVEMENTS	1990	26,015		10			26,015		69
70	TOTAL (lines 4 thru 69)		\$ 4,680,670	\$ 5,609		\$ 120,478	\$ 114,869	\$ 2,489,992		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,680,670	\$ 5,609		\$ 120,478	\$ 114,869	\$ 2,489,992	1
2	LEASEHOLD IMPROVEMENTS	1991	2,141		10			2,141	2
3	WINDOW REPLACEMENT	1992	2,750		10			2,750	3
4	CAFETERIA DOORS	1993	11,918		10			11,918	4
5	PLUMBING WORK	1994	6,858		10			6,858	5
6	PAINTING	1995	3,076	308	10	308		3,076	6
7	WALL AND DOOR REPAIR	1995	2,596	260	10	260		2,596	7
8	DOOR	1996	656	66	10	66		590	8
9	ROOF REPAIR	1996	5,985	598	10	598		5,387	9
10	PAINTING	1996	1,620		10			1,620	10
11	FURNACE	1996	502	50	10	50		452	11
12	LAND IMPROVEMENTS	1996	1,385		3			1,385	12
13	REPAIRS	1996	10,702	103	5	103		10,599	13
14	GRIP CAPS	1996	1,575		5			1,575	14
15	BOILER	1996	3,335	333	10	333		3,002	15
16	BEDDING	1996	1,505		3			1,505	16
17	AIR DEFLECTORS	1996	381		3			381	17
18	SHOWER	1996	259		5			259	18
19	SEWER	1996	9,387	939	10	939		8,449	19
20	PAINTING	1996	4,928	493	10	493		4,435	20
21	ROOF REPAIR	1997	798	80	10	80		639	21
22	DRAPES	1997	4,500		5			4,500	22
23	FLOOR COVERING	1997	1,722	172	10	172		1,378	23
24	DRAPES-LIFE CENTER	1997	3,153		5			3,153	24
25	FLOOR COVERING-LIFE CENTER	1997	4,422	442	10	442		3,538	25
26	PAINTING-LIFE CENTER	1997	8,917	892	10	892		7,134	26
27	FLOOR	1997	2,658	157	10	157		2,343	27
28	ALARMS/SMOKE DETECTORS	1998	20,108		5			20,108	28
29	SNACK LOUNGE REMODELING	1999	2,847		5			2,847	29
30	ROOF REPAIRS	1999	846	85	10	85		529	30
31	CARPET-FRONT OFFICE	1999	8,881		5			8,881	31
32	YARD SIGNS	1999	2,825	283	10	283		1,719	32
33	NEW TEES AND VALVES	1999	11,685	1,168	10	1,168		7,108	33
34	TOTAL (lines 1 thru 33)		\$ 4,825,591	\$ 12,038		\$ 126,907	\$ 114,869	\$ 2,622,847	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,825,591	\$ 12,038		\$ 126,907	\$ 114,869	\$ 2,622,847	1
2	VINYL WALL COVERING	1999	1,127	113	10	113		676	2
3	SHOWER ROOM REPAIRS	1999	8,220	822	10	822		4,932	3
4	CONNECTION FEES FOR SEWER PROJECT	1998	7,438	744	10	744		4,896	4
5	TREE REMOVAL	1999	9,857	986	10	986		5,750	5
6	CONDENSOR	1999	12,396	1,240	10	1,240		7,231	6
7	LEASEHOLD IMPROVEMENTS	1999	2,598	87	5	87		2,598	7
8	LANDSCAPING	1999	18,255	1,826	10	1,826		10,420	8
9	DROP ROD ASSEMBLY	1999	6,408	641	10	641		3,685	9
10	FENCING	1999	3,840	384	10	384		2,176	10
11	TREES	1999	9,905	991	10	991		5,530	11
12	ROOF REPAIRS	2000	2,300	230	10	230		1,227	12
13	TILE FLOOR-RESIDENT WING	2000	34,740	3,474	10	3,474		18,528	13
14	PAINTING	2000	6,352	953	5	953		6,352	14
15	WINDOW REPLACEMENT	1999	2,009	201	10	201		1,055	15
16	LEASEHOLD IMPROVEMENTS	1999	5,754	727	5	727		5,754	16
17	CABINET MODIFICATIONS	1999	4,520	645	7	645		3,551	17
18	PROFESSIONAL ELECTRICAL SERVICES	1999	17,410	1,161	15	1,161		6,964	18
19	NEW SIGN FRONT	1999	900		5			900	19
20	BJC-MASONRY WORK	1999	23,465	1,564	15	1,564		9,386	20
21	PROFESSIONAL PLUMBING AND HEATING	1999	31,000	2,067	15	2,067		12,400	21
22	REMODELING	1999	19,524	1,302	15	1,302		7,810	22
23	PARKING LOT STRIPING	2000	1,549	310	5	310		1,523	23
24	PAINT BASEMENT CEILING	2000	664	133	5	133		598	24
25	DRAPERIES	2001	10,881	2,176	5	2,176		8,388	25
26	RAMP AREA DECORATING	2001	14,387	2,877	5	2,877		11,269	26
27	PAINTING AND WALLCOVERING	2001	8,058	1,612	5	1,612		6,178	27
28	AIR CURTAIN	2001	1,812	259	7	259		992	28
29	RECEPTICLES-BEDROOMS	2001	9,820	1,964	5	1,964		7,201	29
30	SHOWER ROOM FLOOR REPAIRS	2002	1,123	112	10	112		393	30
31	DOOR REPAIRS	2002	6,197	620	10	620		2,077	31
32	BOILER REPAIRS	2002	3,960	792	5	792		2,772	32
33	DRAPERIES	2002	4,200	840	5	840		2,870	33
34	TOTAL (lines 1 thru 33)		\$ 5,116,260	\$ 43,891		\$ 158,760	\$ 114,869	\$ 2,788,929	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,116,260	\$ 43,891		\$ 158,760	\$ 114,869	\$ 2,788,929	1
2	ARCHITECT FEES-REMODEL BATHROOM AREAS	2002	9,863	2,192	3	2,192		9,863	2
3	REPAVE SIDEWALKS	2002	810	81	10	81		263	3
4	TUCKPOINTING	2002	1,490	149	10	149		472	4
5	REPAIR FLOORS	2002	2,688	269	10	269		851	5
6	KEYLOCK PAD	2002	580	58	10	58		169	6
7	STRIP AND REFINISH FLOORS	2002	8,702	870	10	870		2,041	7
8	HOT WATER STORAGE TANK	2002	4,408	441	10	441		1,102	8
9	DOORS AND FRAMES	2003	3,733	373	10	373		840	9
10	POLE LIGHTING-WEST PARKING LOT	2004	3,740	249	15	249		395	10
11	SINK FAUCET AND CABINET	2004	1,133	162	7	162		216	11
12	WALLPAPERING/PAINTING	2004	2,358	157	15	157		157	12
13	DOORS AND FRAMES	2004	4,987	332	7	332		388	13
14	CEILING FANS	2004	1,082	154	15	154		180	14
15	ELECTRICAL WORK	2004	16,000	1,067	15	1,067		1,067	15
16	ALARM SYSTEM	2004	2,204	315	7	315		315	16
17	BOILER-KITCHEN STEAMER	2004	4,871	696	7	696		812	17
18	BOILER	2004	6,900	986	7	986		1,396	18
19	BOILER	2004	7,200	1,029	7	1,029		1,029	19
20	TOILET ROOM ADDITION/RENOVATION	2003	699,826	23,328	30	23,328		35,706	20
21									21
22	HVAC LABOR/MATERIAL	2004	12,497	1,637	7	1,637		1,637	22
23	PARKING LOT	2004	74,847	2,287	30	2,287		2,287	23
24	DENTAL OFFICE RENOVATION	2004	57,955	1,449	30	1,449		1,449	24
25	POLE LIGHT REPLACEMENT	2004	1,868	178	7	178		178	25
26	PARKING LOT SECURITY SYSTEM	2005	20,404	1,449	7	1,449		1,449	26
27	STORAGE ROOM	2005	2,375	282	15	282		282	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,068,781	\$ 84,081		\$ 198,950	\$ 114,869	\$ 2,853,473	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 596,047	\$ 73,502	\$ 73,502	\$	var	\$ 423,626	71
72	Current Year Purchases	43,718	3,447	3,447		7	3,447	72
73	Fully Depreciated Assets	1,036,056	5,953	5,953		7	1,036,056	73
74								74
75	TOTALS	\$ 1,675,821	\$ 82,902	\$ 82,902	\$		\$ 1,463,129	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY RESIDENT	TRUCKS	VARIOUS	\$ 72,449	\$ 6,923	\$ 6,923	\$	3	\$ 70,643	76
77	TRANSPORTATION	VANS/WHEELCHAIR LIFT	VARIOUS	34,424	2,709	2,709		3	33,521	77
78		AUTOS	VARIOUS	41,823	500	500		3	41,031	78
79										79
80	TOTALS			\$ 148,696	\$ 10,132	\$ 10,132	\$		\$ 145,195	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,893,298	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,115	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 291,984	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 114,869	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,461,797	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	REMODELING	\$ 3,443	92
93	LAND IMPROVEMENTS	11,368	93
94			94
95		\$ 14,811	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **FRANCISCAN BROTHERS OF THE HOLY CROSS**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **NONE** Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning **1975**

Ending **2011**

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **6/30/2006** \$ **270,000**

13. **6/30/2007** \$ **270,000**

14. **6/30/2008** \$ **270,000**

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA <u>40</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA <u>85</u>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		473		473
3	Classroom Wages (a)		7,377		7,377
4	Clinical Wages (b)		13,567		13,567
5	In-House Trainer Wages (c)		4,917		3,445
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	26,334	\$	24,862
10	SUM OF line 9, col. 1 and 2 (e)	\$	26,334		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ NONE

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	17
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	17

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
			# of prescrpts								
9	Pharmacy										9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,109,425	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	552,238		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,439		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,701,102	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,788,766		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,687,701		15
16	Equipment, at Historical Cost	1,824,516		16
17	Accumulated Depreciation (book methods)	(2,183,799)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONST IN PROGRESS	3,443		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,120,627	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,821,729	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 326,256	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,207		30
31	Accrued Taxes Payable (excluding real estate taxes)	64,234		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED VACATION	60,928		36
37	OTHER	259		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 522,884	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 522,884	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,296,845	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,819,729	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,970,822	1
2	Restatements (describe):		2
3	CONTRIBUTIONS NOT RECORDED IN PRIOR YEARS	378,883	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,349,705	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(52,860)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (52,860)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,296,845	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,538,733	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,538,733	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	28,982	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,929	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,911	23
D. Non-Operating Revenue			
24	Contributions	367,223	24
25	Interest and Other Investment Income***	87,834	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 455,057	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RENTAL INCOME	1,800	28
28a	INSURANCE PROCEEDS	29,110	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,910	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,059,611	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	908,251	31
32	Health Care	1,639,300	32
33	General Administration	905,450	33
B. Capital Expense			
34	Ownership	447,110	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	212,360	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,112,471	40
41	Income before Income Taxes (line 30 minus line 40)**	(52,860)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (52,860)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number **BROTHER JAMES COURT**

0020495

Report Period Beginning: 7/1/04

Ending:

6/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	2,216	2,080	\$ 54,364	\$ 26.14	1
2 Assistant Director of Nursing					2
3 Registered Nurses	422	422	6,578	15.59	3
4 Licensed Practical Nurses	15,440	16,882	267,285	15.83	4
5 CNAs & Orderlies					5
6 CNA Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides					8
9 Activity Director					9
10 Activity Assistants					10
11 Social Service Workers	3,120	3,120	53,004	16.99	11
12 Dietician					12
13 Food Service Supervisor	3,120	3,120	50,004	16.03	13
14 Head Cook					14
15 Cook Helpers/Assistants	25,007	28,010	232,601	8.30	15
16 Dishwashers					16
17 Maintenance Workers	4,178	4,360	56,565	12.97	17
18 Housekeepers	6,168	6,754	63,636	9.42	18
19 Laundry	4,207	4,622	53,563	11.59	19
20 Administrator	3,120	3,120	57,996	18.59	20
21 Assistant Administrator					21
22 Other Administrative	10,359	11,277	164,461	14.58	22
23 Office Manager					23
24 Clerical					24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)	7,567	7,998	103,080	12.89	28
29 Resident Services Coordinator	3,120	3,120	50,004	16.03	29
30 Habilitation Aides (DD Homes)	97,082	104,913	1,017,415	9.70	30
31 Medical Records					31
32 Other Health Care(specify)					32
33 Other(specify)					33
34 TOTAL (lines 1 - 33)	185,126	199,798	\$ 2,230,556 *	\$ 11.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant	30	\$ 1,213	2,3	35
36 Medical Director	VAR	2,400	9,3	36
37 Medical Records Consultant				37
38 Nurse Consultant				38
39 Pharmacist Consultant	VAR	3,100	10,3	39
40 Physical Therapy Consultant				40
41 Occupational Therapy Consultant	33	954	10a,3	41
42 Respiratory Therapy Consultant				42
43 Speech Therapy Consultant	66	2,640	10a,3	43
44 Activity Consultant	104	2,576	10a,3	44
45 Social Service Consultant	VAR	5,100	12,3	45
46 Other(specify)				46
47 PSYCHOLOGY CONSULTANT	VAR	7,200	10a,3	47
48 EDUCATIONAL CONSULTANT	VAR	597	15,3	48
49 TOTAL (lines 35 - 48)	233	\$ 25,780		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses		\$		50
51 Licensed Practical Nurses				51
52 Certified Nurse Assistants/Aides				52
53 TOTAL (lines 50 - 52)		\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **BROTHER JAMES COURT**

STATE OF ILLINOIS

0020495

Report Period Beginning:

7/1/04

Ending:

Page 23

6/30/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. NA
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? NA
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,545 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. NA
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 212,360
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? NA Indicate the amount. \$ NA
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 5,787
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SIKICH GARDNER & CO, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.